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DATE NOTICE SENT TO ALL PARTIES: Nov/12/2015

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: L4-L5 interlaminar epidural steroid injection

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION: MD, Board Certified Anesthesiology

REVIEW OUTCOME: Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

[X] Upheld (Agree)
[ ] Overturned (Disagree)
[ ] Partially Overturned (Agree in part/Disagree in part)

Provide a description of the review outcome that clearly states whether medical necessity exists for <u>each</u> health care service in dispute. It is this reviewer's opinion that medical necessity for L4-L5 interlaminar epidural steroid injection has not been established

PATIENT CLINICAL HISTORY [SUMMARY]: The patient is a XX year old female who was injured on XX/XX/XX while working. The patient developed complaints of low back pain radiating to the left lower extremity. The patient is noted to have undergone a prior laminectomy at L5-S1 to the left side completed on 12/03/14. The patient was referred for postoperative physical therapy which has been extensive through September of 2015. Postoperative medications did include Alprazolam. Updated MRI studies of the lumbar spine from 03/11/15 noted a 3mm disc protrusion at L5-S1 contacting the descending S1 nerve roots bilaterally. There was no central stenosis and facet hypertrophy was noted contributing to mild exit foraminal stenosis. Postoperative changes at L5-S1 were evident. The original surgery was completed 07/16/15 report did recommend an L4-5 epidural steroid injection. There was no indication that this procedure was performed after the 07/16/15 evaluation. There were no further clinical evaluations. The patient was seen on 09/03/15 for continuing complaints of pain in the lumbar region with radiating numbness and pain in the lower extremities, mostly to the left side. The patient reported not taking medications at this evaluation. The patient's physical examination was difficult to interpret due to handwriting. There did not appear to be any focal neurological deficits.
The epidural steroid injection at L4-5 was denied by utilization review on 07/24/15; however, no specific rationale for the denial was noted.

The request was again denied on 09/10/15 as it was unclear whether the request was for an initial or repeat epidural steroid injection. There was also no documentation regarding a failure of exercises or medications. There was also no official MRI study available for review.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION: The patient had persistent complaints of low back pain affecting the left lower extremity despite surgical intervention in December of 2014. The records did include the MRI study of the lumbar spine from March of 2015 which did note a 3mm disc protrusion at L5-S1 causing some abutment of the S1 nerve roots bilaterally. At the L4-5 level, there was no significant pathology to include central stenosis or

foraminal narrowing. The patient's most recent clinical evaluations did not identify any focal neurological deficits. It is also unclear what the patient's overall response was to physical therapy that continued through September of 2015. No updated clinical evaluation was available for review. Given the insufficient objective evidence regarding an ongoing active L4-L5 radiculopathy, it is this reviewer's opinion that medical necessity for L4-L5 interlaminar epidural steroid injection has not been established and the prior denials remain upheld.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

[ ] ACOEM-AMERICA COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE

[ ] AHCPR-AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES

[ ] DWC-DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES

[ ] EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN

[ ] INTERQUAL CRITERIA

[X] MEDICAL JUDGEMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

[ ] MERCY CENTER CONSENSUS CONFERENCE GUIDELINES

[ ] MILLIMAN CARE GUIDELINES

[X] ODG-OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES

[ ] PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR

[ ] TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS

[ ] TEXAS TACADA GUIDELINES

[ ] TMF SCREENING CRITERIA MANUAL

[ ] PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)

[ ] OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)